UHS Georgia Behavioral Health

Media Statement in response to follow-up questions: WXIA-TV "11 Alive" – April 5, 2019

In addition to our detailed initial statement, we provide the following in response to your further questions:

Police Reports

"…attached the cases of abuse we are referencing in our report."

Please be very careful with statements such as this. It is not accurate to impose a blanket characterization of "abuse" based upon a word or words written in the "Incident type" field in police report. Please consider:

- When 911 is called, Police come in tandem with EMS. If a patient is experiencing medical distress, we call 911. As stated previously, many of our patients are quite ill – with physical ailments in addition to their mental illness.
    - Both of the deaths referenced at SummitRidge, as well as the one at Turning Point, were individuals who passed away as a result of medical ailments. While we always do an internal investigation and cooperate fully with the authorities, no foul play was suspected, no charges were filed. This was not abuse. Further, there have not been any lawsuits filed and no regulatory agencies have made findings against the facilities associated with these matters.
      Some of our patients may have medical co-morbidities (known or unknown) which can cause physical complications and even death. We have processes and procedures in place to address such situations but sometimes medical complications occur that are not preventable or treatable through no fault of the facility and its personnel.
    - There were no deaths due to physical altercations or restraint, other than Austin Skidmore at Laurel Heights.
    - There were no suicides.

- With respect to "Suicide Attempt," while an incredibly significant event, this is not abuse and it would be improper to categorize such an act as "abuse." Patients frequently come to us with suicidal ideations or after having attempted suicide (in some cases, multiple times). If they attempt suicide under our watch (which is very rare due to all our precautions), it's our job to catch them. And we do. Following such an event, we send the patient out to a medical ER for evaluation; hence the EMS/police involvement.
  It is the practice at all UHS Behavioral Health facilities to create an environment of care that will foster the accurate identification and successful management of patients who are at an increased risk for suicide or self-destructive behaviors. Patients at higher risk for suicide and/or self-destructive behavior require intensive support, active supervision, frequent re-assessment and indicated protective measures for their emotional and physical well-being at all times.
  The scope of each facility's suicide prevention activities includes not only individual patient assessment and care that begins prior to admission and continues through the patient's

discharge, but also the organization-wide measures taken to create a safe, ligature-resistant environment with well-trained staff who provide care and support.
Ligature-resistant fixtures at our facilities – including furniture, bathroom plumbing, shower curtains, door handles, hinges, pipes and closures – are specially designed in order to prevent the attachment of anything that could be looped or tied to it for the purpose of hanging or strangulation.

- The cases where the perpetrator is "Patient" and the victim is "Adult" are situations where patients have hit or otherwise physically harmed a staff member. Our staff members are trained in verbal de-escalation techniques and go to great effort to keep everyone safe, but there are sadly situations (again, rare cases) where patients physically harm staff members.

- It is not appropriate or fair to classify "Juvenile disorderly conduct" or "Adult Overdose" as "abuse".

- There are a few cases where multiple police reports were generated for one incident because multiple individuals were involved – e.g., the "Juvenile multiple abuse" set at Coastal Harbor.

As previously stated, it is important to note that the information contained in a police report filed following a visit represents a snapshot in time, may omit facts and context, and is not typically updated when the investigation concludes. UHS facilities fully cooperate with the authorities in all cases. Even the incidents generating police calls related to allegations of improper behaviors or improper care are often ultimately determined through investigation to be unsubstantiated. Due to patient privacy laws, we are unable to provide details of each individual police call.

It is inappropriate to draw conclusions about the quality of care at any facility based solely upon review of initial police reports.

<u>Questions on Specific Incidents</u>

As related to the patient death at **Laurel Heights** in 2016:

> *Austin Skidmore died in our care, and for that we are responsible. As per the official documentation following autopsy, he aspirated at some point during the altercation. Following the incident, the facility conducted a thorough internal investigation, cooperated with authorities, and retrained staff.*

As related to the alleged sexual involvement of two patients at **Laurel Heights**:

> *As soon as the staff became aware of the alleged behavior, the facility promptly notified the appropriate state agencies. Note that Georgia Mandated Reporter Law requires notifying the relevant state agencies only; not necessarily the police.*
> *Staff is trained on proper notification.*

As related to your follow-up questions regarding the incident at **Anchor Hospital** in early 2017:

> *What we are saying is: this was not a rape. This was a planned event between the patients involved as well as other patients, working together to keep staff from discovering them. The fact that the criminal charges were dropped is consistent with this not being classified as a rape.*

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